Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH HEB
3255 WEST PIONEER PARKWAY
ARLINGTON TEXAS 76013

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-13-0668-01

MFDR Date Received
November 9, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the applicable Texas fee schedule the correct allowable would be: 97033 x 3 Charge $303.00 APC fee allowed $138.52 You Payment $0.00 Balance Due $138.52."

Amount in Dispute: $138.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request. A copy of the DWC060 packet was placed in the carrier representative box 19, Flahive, Ogden & Lawson on November 16, 2012 and was picked stamped picked up by 'FOL Fileroom Gorden Clayton' on November 19, 2012. A decision will therefore be issued with the information presented for review at the time of the audit.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 3, 2012 through May 10, 2012	97033 x 3	$138.52	$138.52

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedures for professional medical services rendered on or after March 1, 2008.
3. 28 Texas Administrative Code §134.203 sets out the outpatient facility fee guidelines.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W2 ON68 – According to Medicare guidelines the efficacy of this procedure has not been proven. Service is denied as not being safe and effective.

Issues

1. What division guideline applies for physical therapy services rendered in an outpatient facility setting?
2. Did the requestor bill for services in conflict with the NCCI edits?
3. Did the requestor submit documentation to support that the services were rendered as billed?
4. Is the requestor entitled to reimbursement?

Findings

1. Because no contract exists, reimbursement for the services in dispute is established under 28 Tex. Admin. Code §134.403 (f) which states "The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied…" Therefore, the division must first determine the Medicare OPPS payment, and then apply the minimal modifications required by §134.403 (f) in order to establish the MAR.

   Pursuant to division rule at 28 TAC §134.403(h), "For medical serviced provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided. The Division finds that Medicare reimburses this service using other Medicare fee schedules. The reimbursement shall therefore be made using the applicable Division Fee Guideline. The applicable Division Fee Guideline for physical and rehabilitation is set forth in Division rule at 28 TAC 134.203(c)(1).
2. 28 Texas Administrative Code §134.203 states in pertinent part, "(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." NCCI edits were run to determine if edit conflicts exist for each disputed date of service indicated below. Review of the documentation finds the following;
   - The requestor billed the following CPT codes on May 3, 2012, May 7, 2012 and May 10, 2012; 97033-GO (one unit per date of service), 97035-GO (one unit per date of service) and 97110-GO (two units per date of service).

     NCCI edits were run to identify if the billed charges contain NCCI edit conflicts and no edit conflicts were identified for CPT codes 97033-GO, 97035-GO and 97110-GO, as a result reimbursement will be calculated according to the applicable guidelines.
3. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications: For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

- Dates of service: May 3, 2012, May 7, 2012 and May 10, 2012:
- Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense.
- Procedure code 97033, service date May 3, 2012, May 7, 2012 and May 10, 2012 represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.26 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.26. The practice expense (PE) RVU of 0.63 multiplied by the PE GPCI of 0.979 is 0.61677. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.88503 is multiplied by the Division conversion factor of $54.86 for a MAR of $48.55. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $48.55 x 3 dates of service, for a recommended reimbursement amount of $145.65. The requestor seeks reimbursement in the amount of $138.52, therefore this amount is recommended.

4. Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $138.52. The requestor submitted documentation in the form of an EOB and a cashed check addressed to requestor's address supporting that payment was issued for the disputed services, therefore a dispute does not exist over the lack of payment. As a result, no additional payment is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $138.52.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $138.52 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 26, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.